How to Write GIRP Notes: A Complete Guide with Examples

Clear and accurate documentation is a critical part of effective behavioral health care. **GIRP notes** provide a structured framework that helps therapists and other mental health professionals record client progress, interventions, and treatment plans in a consistent and organized manner. Standing for Goal, Intervention, Response, and Plan, the GIRP format focuses on tracking therapeutic outcomes while supporting continuity of care.

Whether you're new to clinical documentation or looking to improve your note-writing process, understanding how to create effective GIRP notes can save time and enhance record quality. This guide explains each section of a GIRP note and includes practical examples to help you document with confidence.

CLINICAL DOCUMENTATION

BEHAVIORAL HEALTH

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The Documentation Dilemma

Accurate clinical notes are more than an administrative task – they are the backbone of defensible, payer-approved care.

Beyond Descriptive Summaries

Move from vague session descriptions to goal-anchored clinical evidence that demonstrates real progress.

Payer Accountability

Insurance reviewers demand a clear, traceable link between each session and the established treatment plan.

Eliminating Treatment Drift

The GIRP framework keeps every session focused on measurable outcomes, preventing unfocused or redundant care.

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What is a GIRP Note?

The **GIRP format** is the gold standard for goal-driven behavioral health documentation. Each letter represents a distinct clinical element, creating a structured, auditable record of therapeutic work.

Unlike free-form notes, GIRP ensures every session is tied directly to the treatment plan – making it easier to demonstrate medical necessity, track outcomes, and maintain continuity of care across providers.

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G – GOAL

The Goal-First Foundation

The Goal section is the anchor of every GIRP note. It must reference a **specific, measurable objective** from the client's treatment plan – not a generic description of the session.

✅ Best Practice

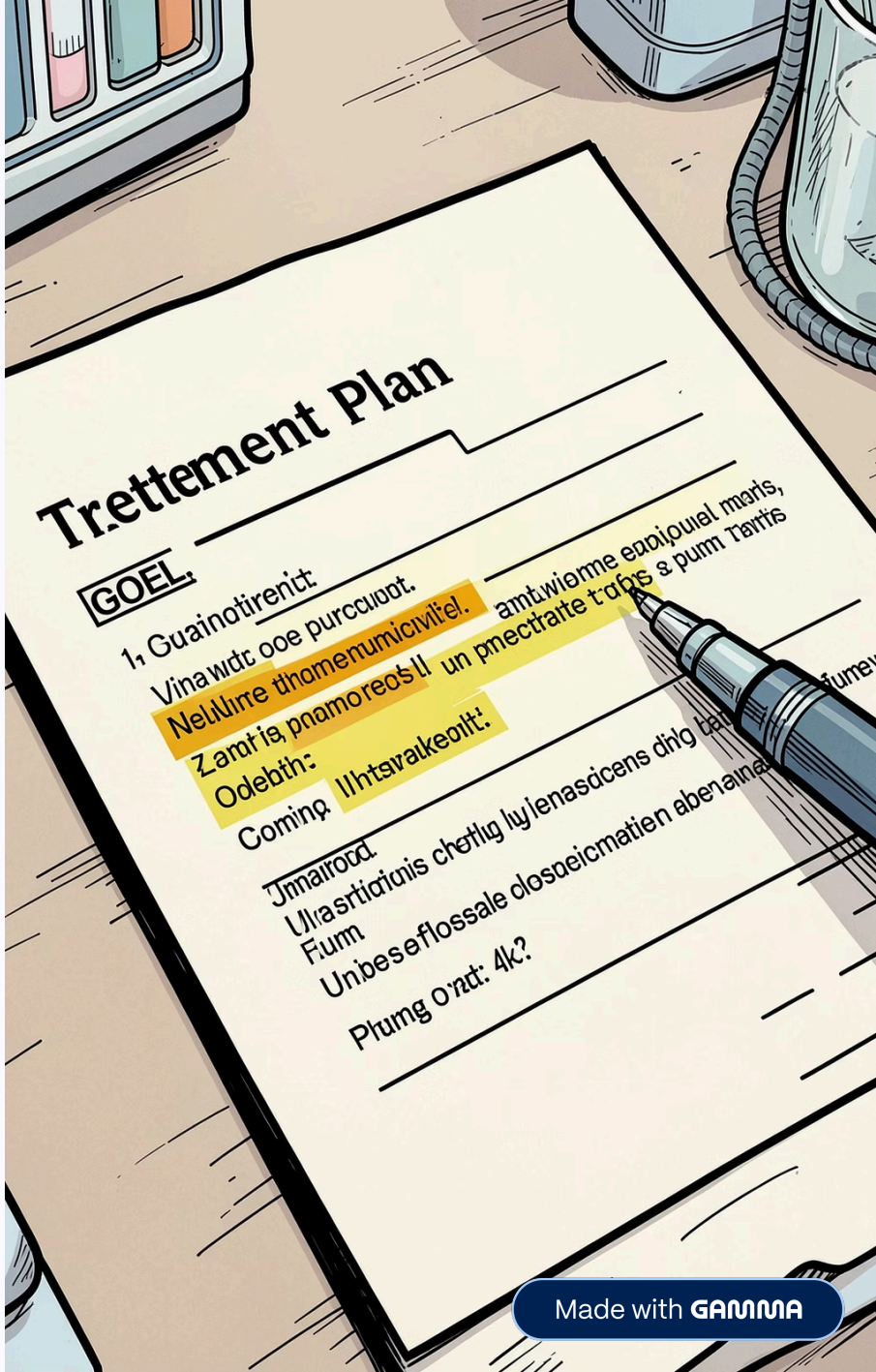
Copy the goal directly from the treatment plan to ensure audit-proof consistency and alignment with payer requirements.

❌ Common Pitfall

Avoid vague phrases like "attend therapy" – these offer no measurable benchmark and weaken medical necessity.

📋 What to Include

Treatment plan identifier, target behavior or symptom, and a measurable outcome with a timeline.



I – INTERVENTION

Clinical Interventions: Precision Matters

What Belongs Here

Name the **specific modality, technique, or psychoeducation** provided during the session. Generic descriptions like "talked about feelings" do not demonstrate medical necessity.

- Identify the therapeutic approach (e.g., CBT, DBT, Motivational Interviewing)
- Describe the specific technique or skill taught
- Link the action directly to the stated goal

Example

"Utilized CBT cognitive restructuring to address distorted thought patterns related to panic episodes, specifically targeting catastrophizing beliefs."

Clear, specific, and directly tied to the treatment goal – exactly what reviewers look for.

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R – RESPONSE

The Client's Response

The Response section captures an **objective account** of how the client reacted to the intervention – both verbally and non-verbally. This is the clinical "check-in" point.

Verbal Engagement

What the client said – insights shared, questions asked, or resistance expressed during the session.

Non-Verbal Cues

Observable behaviors such as affect, body language, or emotional regulation during the intervention.

Effectiveness Check

Determine whether the current approach is working or requires clinical adjustment before the next session.

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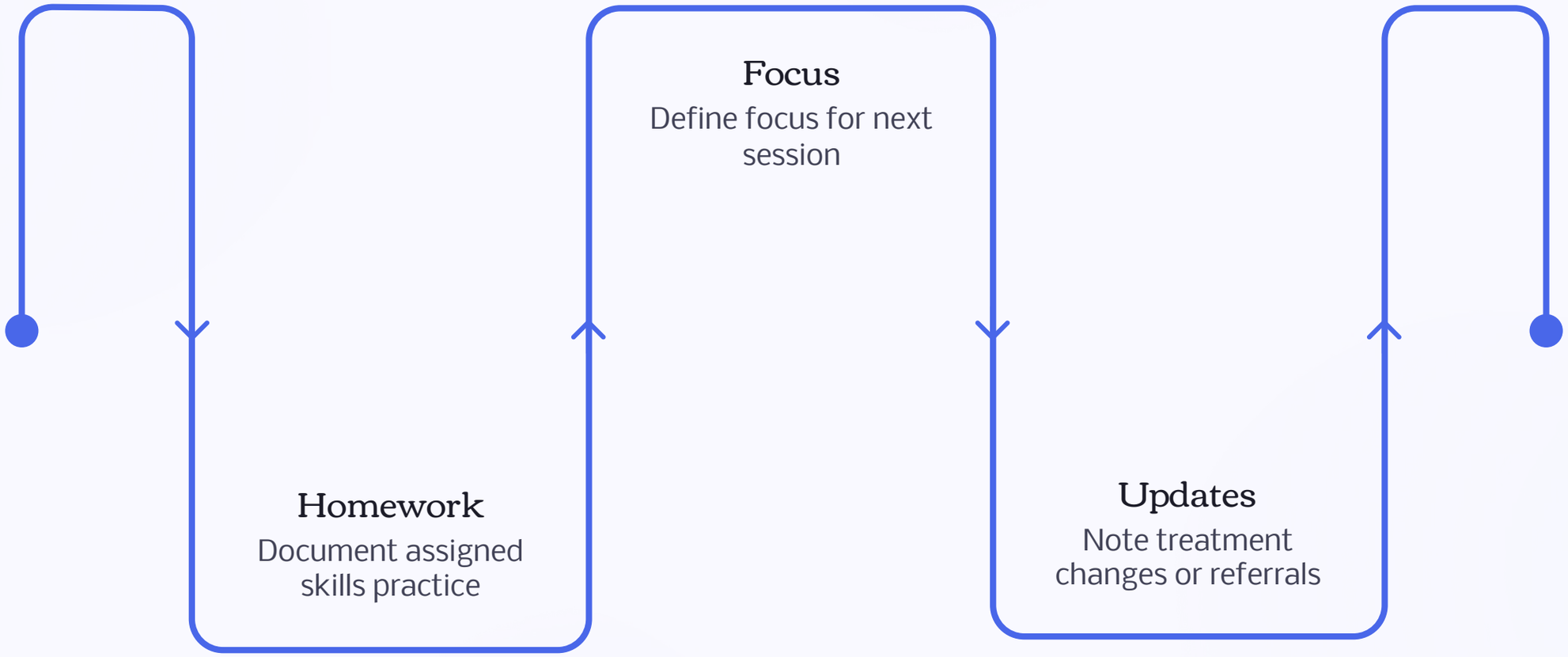
P – PLAN

The Roadmap Forward

The Plan section closes the loop – defining next steps that ensure **continuity between sessions** and sustained treatment progress.



A strong Plan entry specifies what the client will practice between sessions, what the clinician will focus on next, and whether the treatment plan itself needs updating – keeping every session purposeful and connected.

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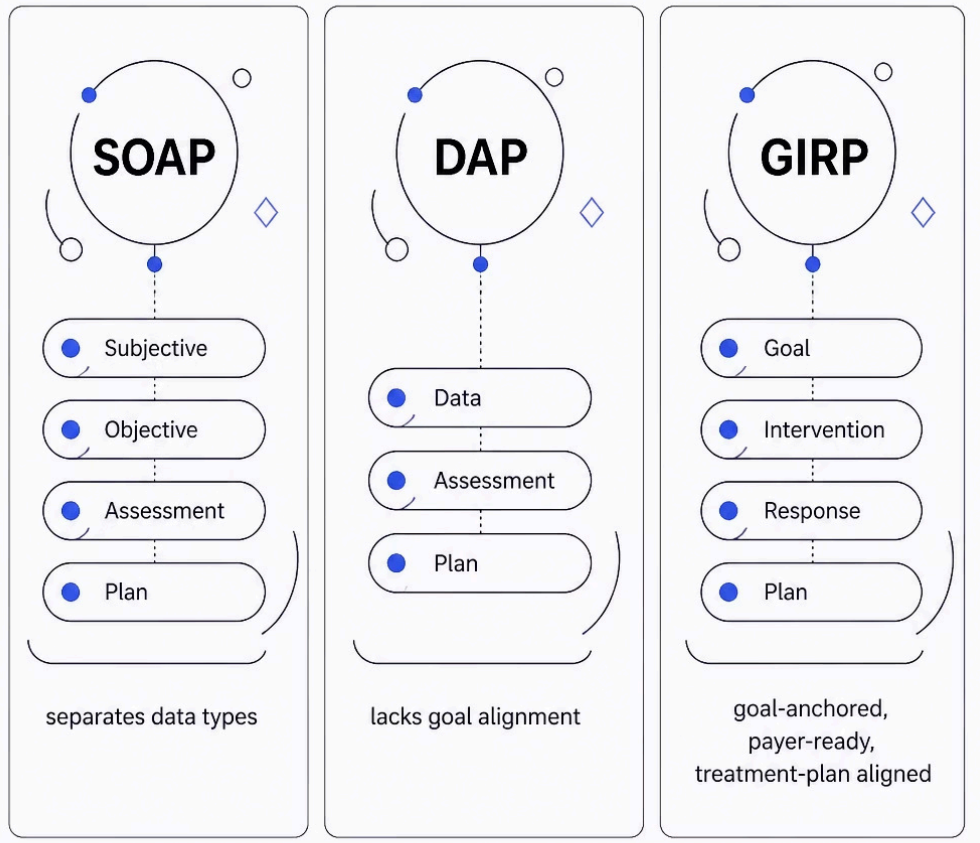
GIRP vs. The Alternatives

In high-scrutiny environments – insurance audits, managed care reviews, and multi-provider settings – **GIRP outperforms both SOAP and DAP** formats by integrating subjective and objective data into a goal-driven structure.



GIRP vs. SOAP

SOAP separates Subjective and Objective data; GIRP integrates them for faster, clearer clinical review.

GIRP vs. DAP

DAP lacks a dedicated Goal section, making it harder to demonstrate alignment with the treatment plan.

Managed Care Ready

GIRP's structure directly supports medical necessity documentation required by payers and auditors.

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Clinical Example: Anxiety & Panic Management

A complete GIRP note in action – demonstrating how each section flows together to create a clear, defensible clinical record.

🎯 Goal

Reduce panic attack frequency to ⩽ 1 per week by 2026-06-01 (Treatment Plan Ref: ANX-04)

⚙️ Intervention

Provided psychoeducation on the panic cycle and guided client through 3 cycles of diaphragmatic breathing.

📊 Response

Client verbalized understanding of the panic cycle; self-reported anxiety reduced from 7/10 to 4/10 post-intervention.

📅 Plan

Homework: practice breathing exercises 2× daily. Next session: begin exposure hierarchy work.

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Mastering Your Documentation Workflow

GIRP notes transform documentation from an administrative burden into a **powerful clinical asset** – protecting you, your client, and your practice.

Consistency Creates Defensible Records

Uniform, goal-anchored notes stand up to audits, payer reviews, and legal scrutiny.

Every Session Needs a Measurable Goal

Start today – anchor every note to a specific, measurable treatment objective from the care plan.

GIRP Is a Clinical Tool, Not Just a Template

Used correctly, it sharpens clinical thinking and improves outcomes – not just compliance.